No. 80-419

# In the Supreme Court

OF THE

# United States

OCTOBER TERM, 1980

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STATE OF ARIZONA,
*Petitioner,*

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE,
and PIMA FOUNDATION FOR MEDICAL CARE,
*Respondents.*

**On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit**

## BRIEF OF CALIFORNIA DENTAL SERVICE AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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## QUESTION PRESENTED

Was the Court of Appeals correct in deciding that the legality under the antitrust laws of reimbursement schedules formulated by Foundations for Medical Care to set the maximum level of reimbursement under Foundation-endorsed health plans could not be determined without consideration of the purposes and competitive effects of such schedules?

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## BRIEF OF CALIFORNIA DENTAL SERVICE AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

This brief is filed on behalf of California Dental Service with the written consent of all parties to this proceeding pursuant to Rule 36 of the Court.

## INTERESTS OF AMICUS CURIAE

California Dental Service ("CDS") is a California non-profit corporation which undertakes to furnish or pay for the provision of dental services to its subscribers in return for premiums paid by them or on their behalf. Presently, approximately 4.5 million individuals, largely in California,

are covered by CDS dental plans. Under the majority of its plans, CDS agrees to pay the full cost of the dental care provided to its subscribers, minus any deductible or co-payment obligation included in the plan.

To secure dental services for its subscribers, CDS undertakes to pay dentists for services provided to CDS patients so long as those dentists agree to keep their fees below a maximum cap which CDS calculates by evaluating the charges of comparably situated dentists. Thus, CDS functions like other third-party payers providing a service benefit—it sets in advance the price it will pay for health care services and relies on comparative data about provider charges to determine that price. While respondent medical foundations perform the same basic task of setting maximum limits on fee reimbursement, the direct role of providers in determining those limits and the absence of any underwriting or risk-assumption by the foundations themselves clearly distinguish their conduct and its potential effects from that of CDS. Nevertheless, in *Manasen v. California Dental Service,* 1981-1 Trade Cases ¶ 63,959 (N.D. Cal. 1980), a plaintiff class of all California dentists challenged CDS's fee mechanism on the ground that it, too, constituted maximum price-fixing, *per se* illegal under Section 1 of the Sherman Act. In *Manasen,* however, the alleged injury was that dental fees were set at too *low* a level by CDS—precisely the converse of the injury claimed by petitioner here. The application of the maximum price-fixing label to such arguably dissimilar conduct demonstrates the potential spill-over effects of the *per se* rule petitioner seeks. Such a rule, by pretermiting consideration of the competitive impact of the conduct at issue, and fo-

cusing instead on the existence *vel non* of a fee ceiling, threatens to invalidate the legitimate cost-containment efforts of third-party payers along with other types of fee ceilings whose purposes or effects may be less benign. CDS files this brief *amicus curiae* to highlight the difficulties in isolating clearly anticompetitive conduct in the health care market, and the necessity for making a detailed inquiry into actual market impact before such a line reliably can be drawn.

## I

## SUMMARY OF ARGUMENT

The decision of the Ninth Circuit is fully in keeping with this Court's historical reluctance to apply the *per se* rule to unique and unfamiliar market behavior. For, the conduct at issue here—the formation of maximum reimbursement schedules for use in provider-endorsed third-party payer health plans—is certainly not a "garden variety" restraint of trade, and its competitive effects are neither well-established nor easily predicted. Moreover, the health care market—the context in which respondents' conduct is to be evaluated—deviates dramatically from the conventional market for goods and services which the *per se* rule takes as its benchmark. The special nature of health care services, the prevalence of third-party payers, and the extent of government regulation make this market a peculiar one in which ordinary competitive forces necessarily operate in a weakened manner. The inevitable result is an imperfect fit between the *per se* rule and the aberrant "competitive" regime that obtains in the health care market. For example, the maximum price-fixing label which petitioner wishes to apply to respondents' conduct in order to invoke the *per se*

rule, has also been seized upon by other actors in the health care market to condemn the pro-competitive cost-containment efforts of third-party payers. The Federal Trade Commission, recognizing the unavoidable spill-over effects of any categorical—*per se*—rule when applied to the diverse third-party payment mechanisms operating in the health care market, adopted a more selective rule of reason approach. The sparse record now before this Court certainly supplies no justification for a contrary result.

## II

## ARGUMENT

Despite petitioner's repeated efforts to treat the Ninth Circuit's decision as either creating a learned professions' exemption to the antitrust laws or repudiating the *per se* rule in price-fixing cases, that decision does neither. Instead, for the court of appeals, like the district court, this case raised only the question of how a particular practice was to be characterized for antitrust purposes. Neither court disputed that the *per se* rule would be the appropriate standard if the challenged practice were ultimately found to constitute price-fixing, but both refused to apply this label without additional evidence as to the purpose and competitive effects of respondents' conduct. And the fact that neither court was familiar with the challenged conduct—the formulation of maximum reimbursement schedules for use by third-party payers—or the market setting in which the conduct occurred materially contributed to this holding.[1]

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[1]The market for health care services and the competitive effects of insurance coverage on that market have rarely been the subject

The reluctance of the courts below to apply the *per se* rule to novel and untested market behavior is fully consistent with the guidance offered by this Court in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.* (*"BMI"*), 441 U.S. 1, 9-10 (1979):

> "[A]s we recognized in *United States v. Topco Associates, Inc.*, 405 U.S. 596, 607-608 (1972), '[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations . . .' *See White Motor Co. v. United States*, 372 U.S. 253, 263 (1963). We have never examined a practice like this one before; indeed, the Court of Appeals recognized that '[i]n dealing with performing rights in the music industry we confront conditions in copyright law and in antitrust law which are *sui generis*.' 562 F.2d at 132. And though there has been rather intensive antitrust scrutiny of ASCAP and its blanket licenses, that experience hardly counsels that we should outlaw the blanket license as a *per se* restraint of trade."

The Court further stressed that the proper test to be followed in determining whether the conduct at issue is *per se* unlawful, is not whether certain labels such as "price-

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of judicial scrutiny under the antitrust laws. Indeed, prior to the recent decisions in *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978), and *Group Life & Health Ins. Co. v. Royal Drug Co.* ("Royal Drug"), 440 U.S. 205 (1979), the McCarran-Ferguson Act had been interpreted as exempting the majority of practices in that market from meaningful antitrust challenge. With the scope of the "business of insurance" exemption recently clarified and narrowed, courts are now being presented for the first time with questions touching the operations of markets in which insurance coverage is an indelible feature—a feature fundamentally at odds with the common equations which operate in the traditional competitive markets for goods and services.

fixing" can "literally" be applied, but instead whether injury to competition can in fact be presumed:

> "More generally, in characterizing this conduct under the *per se* rule, our inquiry must focus on whether the effect and, here because it tends to show effect, see *United States v. United States Gypsum Co.*, 438 U.S. 422, 436, n.13 (1978), the purpose of the practice are to threaten the proper operation of our predominantly free-market economy—that is, whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output, and in what portion of the market, or instead one designed to 'increase economic efficiency and render markets more, rather than less, competitive.' *Id.*, at 441 n.16; *see National Society of Professional Engineers v. United States*, 435 U.S. at 688; *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. at 50 n.16; *Northern Pac. R. Co. v. United States*, 356 U.S. at 4." 441 U.S. at 19-20 (footnote omitted).

The clear lesson of *BMI*, then, is that before unique and unfamiliar market behavior is branded with the *per se* label, a preliminary inquiry into the purpose and competitive effects of the conduct must be undertaken to determine if the preconditions for application of the *per se* rule have been met. And, as this Court observed in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 696 (1978), such an inquiry is doubly necessary when professional services are involved because "professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary." The decision of the Ninth Circuit is entirely in keeping with the approach articulated in *BMI* and *National Society of Professional Engineers*, as is its

conclusion that the rule of reason is the proper standard against which the challenged conduct should be tested.[2]

### A. The Market for Health Care Services Differs Fundamentally From the Traditional Competitive Marketplace Which Per Se Analysis Takes as Its Benchmark

Among the factors considered by the court below as arguing for application of the rule of reason was the uniqueness of the health care market. Contrary to petitioner's claim, however, this factor was not used by the court to suggest that the reasonableness of fixed prices was a defense to a Sherman Act challenge. Rather, Judge Sneed recognized that the special characteristics of the health care market may bear on the question of whether the maximum reimbursement schedules adopted by respondents "would always or almost always tend to restrict competition," *BMI*, 441 U.S. at 19-20—the essential question in determining if the practice at issue should be *per se* unlawful.[3]

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[2]"The traditional framework of analysis under § 1 of the Sherman Act is familiar and does not require extended discussion. Section 1 prohibits '[e]very contract, combination . . ., or conspiracy, in restraint of trade or commerce.' Since the early years of this century a judicial gloss on this statutory language has established the 'rule of reason' as the prevailing standard of analysis." *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49 (1977).

[3]Petitioner repeatedly argues that only the challenged conduct of respondents—not its market setting—should be considered in determining if the *per se* rule is applicable. Such a narrow compass for antitrust analysis finds no support in logic or in the prior decisions of this Court. *See, e.g., BMI, supra*, 441 U.S. at 20 ("ASCAP and the blanket license developed together out of the practical situation in the marketplace. . . ."); *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Association*, 49 U.S.L.W. 4672, 4676 n.19 (June 15, 1981)

The special characteristics of the health care market are, in the first instance, a consequence of the unique nature of health care services and the attitudes of patients and providers regarding those services. Unlike a normal consumer, a purchaser of health care typically does not select the services he receives. Rather, entry into the health care market is usually a response to a set of symptoms or complaints from which one seeks relief, with the provider making the determination of which services are required. The consumer does not necessarily even select the provider of the services, but instead is often referred to a specialist by another provider. Thus the consumer, because he does not know in advance what services he is purchasing or who will provide those services, is unable to make meaningful price comparisons.[4] More, the absence of widespread price advertising deprives the consumer of the information necessary to choose among the options in those limited circumstances where a choice is possible and thus further limits the potential for price competition in this market.[5]

The difficulties the consumer has in comparing the prices of health care services offered by "competing" providers are compounded by the fact that fees for particular serv-

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(lower courts should "give attention to the particular economic context in which the alleged conspiracy and 'refusal to deal' took place.").

[4]Of course, when emergency treatment is rendered, the patient's ability to select the range of services or the provider is reduced even further, and economic considerations are subordinated to concerns for the preservation of life or alleviation of pain.

[5]*See* Conrad & Emerson, *State Dental Practice Acts: Implications for Competition*, 5 Journal of Health Politics, Policy and Law 610 (1981); Benham, *The Effect of Advertising on the Price of Eyeglasses*, 15 Journal of Law and Economics 337 (1972).

ices are frequently not the major determinants of overall health care costs. Rather, the course of treatment or intensity of care may have a far more significant influence on the amount which the patient or his insurer will ultimately have to pay. Different physicians may prescribe very different courses of treatment for the same condition, depending on their perception of the patient's needs and their overall approach or therapeutic philosophy. Yet, patients are generally unaware of treatment options and rarely select one provider over another on this basis. The ability of a provider to effect the demand for and utilization of his services further serves to distinguish the market for health care services from the typical competitive market.

The special relationship between the health care provider and the patient also limits the role played by price in this market. Health care consists not simply of discrete services purchased separately as needed, but instead of a series of related and personal services extending over a considerable period of time. Many consumers are, as a result, reluctant to select new providers mid-stream because of a perceived relationship between continuity and quality of care. This characteristic of health care makes consumer shopping for a better price a rare phenomenon in the health care market as does the widespread perception—in part fostered by government policy—that good health is a fundamental right not to be valued in economic terms.[6]

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[6]*See* National Health Planning and Resources Development Act of 1974, § 2, 42 U.S.C. § 300K(a)(1).

The extent of government involvement in and regulation of the health care market—including efforts both to restrict the supply of services and to influence the prices of such services—also distinguishes this market from the markets for most other goods and services. State laws mandating the licensing of both professional and institutional health care providers are an obvious restriction on entry into the market as are state and federal restrictions on capital expenditures for new health care facilities.[7] And, for the more than one-third of personal health care expenditures paid by the government,[8] there are also direct controls on fee levels as well as on the volume of services provided. Specifically, both the federal Medicare program and the federal-state Medicaid program impose ceilings on fees charged to covered patients.[9] To the extent such ceilings influence the overall level of provider charges, their effects are not necessarily limited to the publicly financed segment of the market.[10] Further, the Professional Standards Review Organizations, established by federal law, directly limit the volume of health care services financed, in whole or in part, by public funds.[11]

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[7]*See National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Association, supra.*

[8]Health Insurance Institute, *Source Book of Health Insurance Data, 1979-80,* 58, citing U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review,* Summer 1979.

[9]*See* Pub.L. 89-97, 42 U.S.C. §§ 1395u, 1395f(h), 1395cc (Medicare); Pub.L. 89-97, 42 U.S.C. § 1396(b)(i)(1) (Medicaid).

[10]*See* Kallstrom, *Health Care Cost Control By Third Party Payers: Fee Schedules and the Sherman Act,* 1978 Duke L. J. 645, 650; Frech and Ginsburg, *Imposed Health Insurance in Monopolistic Markets: A Theoretical Analysis,* 13 Econ. Inquiry 55, 67-69 (1975).

[11]*See* Pub.L. 92-603, Title II, 42 U.S.C. §§ 1320c-1 *et seq.*

The introduction of insurance into the market for health care services further distorts the interplay of normal competitive forces.[12] The reason requires little explanation: widespread insurance coverage[13] shifts the cost of health care services from the consumer of those services to third-party payers. At the time treatment is rendered, an insured patient pays, at most, only a fraction of the actual cost and thus has little financial incentive to question either the need for or the value of such treatment. The existence of health insurance—often paid for by employers—not only makes the patient less concerned about the cost of any particular medical or dental service, but also increases his or her demand for additional and perhaps more expensive care. Thus, at the point of contact between the provider and the patient, normal price constraints on the behavior of either simply fail to operate. *Cf. National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Association, supra,* 49 U.S.L.W. at 4676 (reference to Congressional view that "the health care industry does not respond to classic marketplace forces.")

Instead, to the extent competitive behavior is present at all in the health care market, it results from the bargaining between third-party payers and the providers of health

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[12]*See, e.g.*, Dyckman, *A Study of Physicians' Fees*, Council on Wage and Price Stability 14-21 (1978); Enthoven, *Consumer Centered vs. Job-Centered Health Insurance*, 57 Harv. Bus. Rev. 141 (1979).

[13]In 1978, third-party payments for health care by private health insurers and the government constituted some two-thirds of the total amount spent for personal health care services. Health Insurance Institute, *Source Book of Health Insurance Data, 1979-1980, supra*, at 58.

care services. *See, e.g., United States v. American Soc. of Anesthesiologists,* 473 F. Supp. 147, 160 (S.D.N.Y. 1979). Unlike traditional market transactions, here the ultimate consumer may select the seller but does not bargain with him over price; rather, a surrogate buyer with arguably different interests and incentives—the third-party payer—does what negotiating there is. The peculiarities of this transaction and the regulatory regime in which it takes place yield a competitive order which simply cannot be assumed to duplicate that found in more traditional markets where the *per se* rule has characteristically been applied. Yet, it is in terms of this atypical and unfamiliar market setting, not the idealized model of perfect competition, that respondents' conduct must be judged to determine if it "would always or almost always tend to restrict competition . . ." *BMI, supra,* 441 U.S. at 19-20.

Although the dynamics and competitive consequences of the tri-partite health care transactions described above have not been examined in detail, several key elements or aspects can be identified from the available literature.[14] Clearly, the impulse for price competition in this market—to the extent it exists at all—comes from the insurance company or other third-party payer. In theory, at least, any third-party payer able to reduce its payments to providers can secure an advantage over its competitors by reducing its premiums. Such cost-containment efforts

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[14] *See, e.g.,* Carlson, *Prepaid Prescription Drug Plans Under Antitrust Scrutiny: A Stern Challenge to Health Care Cost Containment,* 75 Nw L. Rev 506 (1980); Havighurst, *Controlling Health Care Costs—Strengthening the Private Sector's Hand,* 1 Journal of Health Politics, Policy and Law 471, (1977).

by insurers—the mechanism through which price consciousness is introduced into the market—depend, however, on the negotiation in advance of an agreement with "participating" providers setting limits on the level of reimbursement.[15] Yet, the reported cases, *see, e.g., Group Life and Health Insurance Co. v. Royal Drug Co., supra; Manasen v. California Dental Serv., supra,* indicate that such agreements have been challenged on maximum price-fixing grounds under *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951), *Albrecht v. Herald Co.*, 390 U.S. 145 (1968) and their various progeny. The apparent collision between the doctrine enunciated in *Kiefer-Stewart* and *Albrecht* and the procompetitive cost-containment efforts of third-party payers is a disturbing one. At the very least, it raises questions about the appropriateness of treating maximum price-fixing as a *per se* offense in a context where maximum restraints may be an indispensable ingredient of competitive conduct. *See* Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?*, 49 Antitrust L. J. 17, 27-28 (1981).

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[15] *See, e.g.*, Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L. J. 303, 326-27; Kallstrom, *Health Care Cost Control by Third Party Payers: Fee Schedules and the Sherman Act, supra.*

**B. The Maximum Reimbursement Schedules Developed by Respondents Are Not "Naked Restraints of Trade With No Purpose Except Stifling of Competition" and Thus Should Be Evaluated Under the Rule of Reason Not the Per Se Rule**

The unique nature of the alleged restraint of trade at issue here—the formulation of maximum reimbursement schedules for use in provider-endorsed health plans—and the unfamiliarity of the courts with it further weakens the argument for *per se* illegality. Originally, respondents utilized relative value schedules ("RVSs") and conversion factors which, when used in conjunction, yielded a schedule of maximum payments to be made by foundation-endorsed plans.[16] The difficulty of analyzing the competitive impact of RVSs has been aptly noted by Professors Havighurst and Kissam:

> "Due to the unusual market circumstances in which RVSs are produced and used, they are not easy to characterize for purposes of antitrust analysis."

Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, 3 Journal of Health Politics, Policy and Law 48, 63 (1979).

First, the purposes of such schedules do not neatly fit into the *per se* price-fixing mold. As even the most vehement critics of RVSs concede:

> "[T]here is some reason to doubt that a traditional price-fixing purpose has been a prime motive behind professionally sponsored RVSs. . . . With reliable sub-

[16]Since the commencement of this litigation, respondents have significantly altered the mechanism followed in determining maximum reimbursement levels for foundation-endorsed health plans.

> stitutes for their services difficult to come by and price competition so attenuated, physicians generally would seem to possess substantial monopoly power and probably feel little need to use RVSs as formulas to make higher prices possible. While firmer conclusions than this about competition among physicians probably cannot be drawn, it does seem unlikely that use of the RVS as a price-fixing formula is an important ingredient in their market power."

Havighurst and Kissam, *supra*, at 55-56. Certainly nothing in this record demonstrates that respondents pressured or forced individual physicians into charging similar fees or adhering to the pricing formula set out in the foundations' schedules. Rather, the central purpose of these schedules was to facilitate physician input into the reimbursement and cost-containment decisions of third-party payers. And, once again, there is no evidence in this record to show that third-party payers were coerced into accepting respondents' maximum reimbursement levels, that foundation members were precluded from dealing with non-endorsed health plans or that the market power of the foundations in fact curbed third-party payers' freedom of action.[17] Absent such

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First, relative value schedules and conversion factors play a substantially reduced role in the process, and, second, foundation members no longer vote on the maximum reimbursement schedules. The analysis, *infra*, responds directly to petitioner's criticism of relative value schedules and conversion factors, but applies with equal if not more force to the new procedures adopted by respondents.

[17]The record contains no expert opinion regarding the economic effects of respondents' conduct nor, more significantly, is there evidence from third-party payers about the nature of their dealings with the foundations or their use of the maximum reimbursement schedules. Simply put, the record provides little more than a de-

evidence, efforts by providers to participate in the determination of maximum insurance reimbursement levels do not seem so patently unreasonable or anticompetitive as to warrant *per se* treatment. Petitioner's rigid adherence to the outmoded notion that all contacts among competitors touching on price are necessarily nefarious and therefore *per se* unlawful accounts for its failure to recognize that other legitimate purposes may also motivate such conduct. *See generally, BMI, supra.*

The market effects of the conduct challenged here are equally uncertain and thus defy *per se* treatment. At base, petitioner seems to contend that the promulgation of maximum reimbursement schedules by providers inevitably serves to inflate the overall level of physician fees. Yet, the available evidence suggests that any link between such conduct and actual charges is far too attenuated to support the categorical prohibition which petitioner seeks. Again, addressing this contention in the context of RVSs, Professors Havighurst and Kissam observed that:

> "Although it would seem that an insurer's adoption of a widely distributed RVS as the basis for its maximum fee screen could easily have the same effect [of allowing physicians to submit claims at the maximum level], a recent study of California RVSs found wide

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scription of the practices of the foundations derived from interrogatory responses and requests for admission. No effort has been made to identify or grapple with the economic effects of the challenged conduct; rather the courts below were asked to assume the worst and then to categorically prohibit the challenged conduct. The inadequacies of the record provided a sufficient basis for the denial of petitioner's summary judgment motion, and render this case, in its present posture, an unsatisfactory vehicle for determining the proper antitrust characterization of respondents' conduct.

> disparity among fee claims submitted to Blue Shield for similar services. Another study of physician's pricing behavior on a statewide basis in twenty-four states also found little evidence that physicians adhere rigorously to RVSs in pricing their insured services. It thus appears that physicians may not have used RVSs systematically to set their fees at maximum reimburseable levels. Perhaps, given the theoretical possibility, this must be regarded as an instance of physicians' departure from the economists' norm of profit maximization."

Havighurst & Kissam, *supra* at 56-57. Much the same conclusion was reached in a recent economic analysis of RVSs:

> "The primary implication that may be drawn from these results is that, while use of a RVS is associated with lower fee dispersions, a RVS does not lead directly to higher fee levels. Combined with the results on insurers, these results provide strong evidence that greater use of RVSs is primarily related to the prevalence of third parties, and that use of RVSs has had no significant positive effect on reimbursement levels. Further, there is some evidence to indicate that use of RVSs in association with third parties may result in limiting reimbursement levels to physicians."

Eisenberg, *Information Exchange Among Competitors: The Issue of Relative Value Schedules for Physician Services*, 23 Journal of Law and Economics 441, 457 (1980).[18] Simply put, the impact of maximum reimburse-

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[18]It is important to distinguish between a reduction in fee dispersion and an increase in average fee levels. While the latter, if the result of contact among competitors, may constitute price-fixing, the former is generally regarded as an indication of market efficiency and the availability of information regarding competitive con-

ment schedules on physician price behavior confounds easy prediction thereby rendering reliance on the *per se* rule literally a "hit or miss" proposition.

Moreover, the absence of any evidence in this record from third-party payers about the nature of their relationship with the respondent foundations is particularly disturbing. For, the competitive effects of respondents' conduct may depend on whether third-party payers play an active role in reimbursement decisions or instead passively accept whatever level of fees respondents suggest. Indeed, in its study of physician control of third-party payers, the FTC's Bureau of Competition concluded that "to the extent [foundations] must negotiate at arm's length with independent underwriters over the terms on which coverage will be offered to subscribers," an effective check may be placed on the anticompetitive effects generated by "provider control" in other contexts. FTC Bureau of Competition, Staff Report, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans* 332-33 (April 1979). In all events, questions about the market behavior of insurers when faced with

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ditions. Consumer search behavior is one mechanism whereby such information is gathered and communicated in the normal market setting; an alternate method is the exchange of price information among producers or providers. Particularly in the health care market where consumer "shopping" is infrequent, exchange of pricing information through RVSs or in some other fashion may be the only available method for disseminating such data and thereby eliminating the "pockets of glut and shortage" that a wide dispersion of fees or prices may yield. *See generally*, Posner, *Information and Antitrust: Reflections on the Gypsum and Engineers Decisions*, 67 Geo. L. Rev. 1187 (1979).

provider-generated maximum reimbursement schedules are empirical ones which can only be answered after an evidentiary inquiry of precisely the type prohibited by the *per se* rule.

### C. The Recent Decision of the FTC Not to Promulgate an Industrywide Rule Barring Physician Control of Third-Party Payers Provides Additional Justification for the Decision Below

In 1979, the Federal Trade Commission's Bureau of Competition released the results of its study of the involvement of physicians in the governance and administration of open-panel medical prepayment plans. FTC Bureau of Competition, Staff Report, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Prepayment Plans, supra,* ("Medical Participation"). That study and an accompanying economic analysis by the FTC's Bureau of Economics, Kass & Paulter, *Physician Control of Blue Shield Plans* (November 1979), reached the conclusion that:

> "[M]edical participation in the control of many Blue Shield plans is sufficiently great that physicians and physician organizations are able to control or influence economically significant decisions made by the plans. These decisions concerned how much to pay physicians, whether or not to pay non-physician health professionals who compete with physicians, what cost-containment mechanisms to employ and other matters that affect competition in the professional health services section of the nation's economy."

*Medical Participation, supra,* at 1. The study also concluded that foundation-sponsored health plans, like those

endorsed by respondents here, raised related, if not identical, antitrust issues to those raised by physician control of Blue Shield. *Id.* at 306-07.

As a remedy for the anticompetitive conduct which it identified, the Bureau recommended an industrywide rule barring, *inter alia,* direct or indirect control of open-panel medical payment plans by any physician organization on the ground that such control constituted an unfair method of competition under Section 5 of the FTC Act. The scope of the proposed rule was intended to be quite broad covering:

> "All open-panel plans—including medical service bureaus, FMC's [Foundations for Medical Care] and IPA-type HMO's—because medical control of all such plans apparently involves joint fee-setting activity by physicians who otherwise compete with each other."

*Id.* at 330. *See* 45 Fed. Reg. 17,019 (March 17, 1980) (initial request for comments on proposed rule-making).

Comments on the staff's recommendation and further studies undertaken by the General Accounting Office and the FTC Bureau of Economics,[19] however, raised doubts that the nexus between physician involvement in pre-paid health plans and higher levels of physician reimbursement was as direct and inevitable as the staff's request for rule-making—essentially a *per se* approach—had suggested. Instead, those comments and studies persuaded the Commission that:

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[19]General Accounting Office, *Public Representation On Boards And Blue Shield Allowances: Important Relationships Not Found* (1980); Anderson, Kass & Pautler, *Physician Control of Blue Shield Plans: A Further Discussion of the Issues* (1981).

> "[I]ndustrywide rule-making is not the appropriate way to address these concerns. Rule-making does not appear to be the most appropriate remedy, because the Commission has concluded that medical control of prepayment plans is not always anticompetitive despite the potential for abuse, and because *it may not be feasible to devise a rule that clearly distinguishes between procompetitive and anticompetitive agreements.* . . ."

46 Fed. Reg. 27768-69 (May 21, 1981) (emphasis added). The Commission went on to note that analysis of the competitive impact of agreements between physicians and third-party payers would involve consideration of a broad range of factors including:

> "the purpose behind the agreement; the type of physician group involved; the market power of the plan and physician group; the extent of control exercised by the group; the particular practices adopted by the controlled plan and their effects on price, coverage and other competitive factors; and any procompetitive business justifications for such plan practices."

*Id.*

In sum, the FTC, after a detailed study and analysis of the competitive consequences of provider control of third-party payers by, *inter alia,* foundations like respondents here, rejected the *per se* approach which petitioner—on the strength of a far less adequate record—now urges this Court to adopt. Rather the Commission, recognizing the peculiarities of the market setting and the fee mechanisms involved, chose to apply the rule of reason and consider the competitive effects of the various reimbursement mechan-

isms at issue.[20] *See* Statement of FTC Commissioner David A. Clanton *reprinted in* CCH Trade Regulation Reports No. 487, p. 9 (April 27, 1981) (Economic studies and other factors "emphasize the need to proceed in a more selective fashion, using a rule of reason approach.") While the FTC's determination is, of course, not binding on this Court, its conclusion—reached after a detailed and wide-ranging investigation—cannot be ignored in analyzing respondents' practices. *Cf., BMI, supra,* 441 U.S. at 13. For the FTC's adoption of the rule of reason approach stands as a direct refutation of petitioner's claim that conduct like that of the respondents here inexorably and ineluctably restrains competition.

Moreover, the FTC's discriminating approach to regulation in this area reflects the difficulty of attempting to apply a categorical rule to the variegated third-party payer mechanisms operating in the health care market. As the reported cases illustrate, the perceived economic effects of these mechanisms differ dramatically depending on the vantage point from which they are surveyed. For example, in *Royal Drug, supra,* high cost pharmacies contended that the maximum cap on reimbursement levels reflected predatory conduct by the insurer and lower cost pharmacies to force them out of the market. In the instant case, by contrast, petitioner argued that providers were

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[20]The recent decision in *Michigan State Medical Society,* Trade Reg. Rep (CCH) ¶ 21,836 (FTC June 30, 1981), exemplifies this approach. There the administrative law judge—after considering the *competitive effects* of the Medical Society's efforts to regulate the reimbursement policies of Blue Cross, Blue Shield and Medicaid—concluded that the antitrust laws had been violated.

imposing high-cost reimbursement schedules on the third-party payers to the detriment of the consuming public. In *Manasen, supra,* it was the providers who complained that the third-party payers conspired with their subscribers to impose lower fee ceilings on them. And in *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania,* 481 F.2d 80 (3d Cir. 1972), *cert. denied,* 414 U.S. 1093 (1973), a competing insurer alleged that Blue Cross—by imposing a limit on payments for services rendered to its subscribers—was gaining an unfair competitive advantage over other third-party payers. Yet in all four cases, the same basic antitrust issue was raised—the status of maximum limits on fees or reimbursement levels under Section 1 of the Sherman Act.

It is thus apparent that in this special market setting, labels will not substitute for analysis. Institutional factors like the nature of the market for health care services, the extent of competition among insurers, the market power of such insurers, and the nature and scope of provider control of these insurers must be analyzed before the competitive impact of any particular fee-setting mechanism can be determined. Given the capacity of the *per se* doctrine to strike down the benign in the quest for judicial efficiency and guidance, that doctrine should be employed only when experience teaches that the risk of error is *de minimis.* This record and the judiciary's limited exposure to market behavior like that of respondents do not provide the experience required to make that judgment here.

## CONCLUSION

For the foregoing reasons, the decision of the Ninth Circuit should be affirmed.

Dated: August 4, 1981

Respectfully submitted,
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**(Appendix follows)**

## APPENDIX

Attorney General [Letterhead]
State Capitol
Phoenix, Arizona 85007

Robert K. Corbin

April 7, 1981

Robert A. Rosenfeld, Esq.
Heller, Ehrman, White & McAuliffe
44 Montgomery Street
San Francisco, California 94104

Re: State of Arizona v. Maricopa County Medical Society, No. 80-419

Dear Mr. Rosenfeld:

This letter is in response to your request of March 31, 1981, for consent to the filing of an amicus curiae brief by the California Dental Service on behalf of the respondents in the referenced case. The State of Arizona has no objection and hereby consents.

Very truly yours,
ROBERT K. CORBIN
Attorney General

/s/ CHARLES L. EGER
CHARLES L. EGER
Assistant Attorney General
Antitrust Division

Brown & Bain [Letterhead]
A Professional Association
222 North Central Avenue
P.O. Box 400
Phoenix, Arizona 85001
(602) 257-8777

April 2, 1981

State of Arizona v.
Maricopa County Medical Society

Dear Mr. Rosenfeld:

Confirming our telephone conversation, I am authorized on behalf of all respondents to confirm that they have no objection to California Dental Service filing a brief *amicus curiae* in the above-captioned matter.

With respect to the briefing schedule, the parties have agreed that petitioner's brief and the joint appendix may be filed by June 5, 1981 and respondents' briefs by August 24, 1981. Of course, the foregoing is subject to approval by the Court.

Please feel free to call me if you have any further questions about the case. I hope that we will have an opportunity to get together in the near future.

Yours truly,

/s/ PHILIP P. BERELSON
Philip P. Berelson

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